

PAIN & OPIOID USE DISORDER



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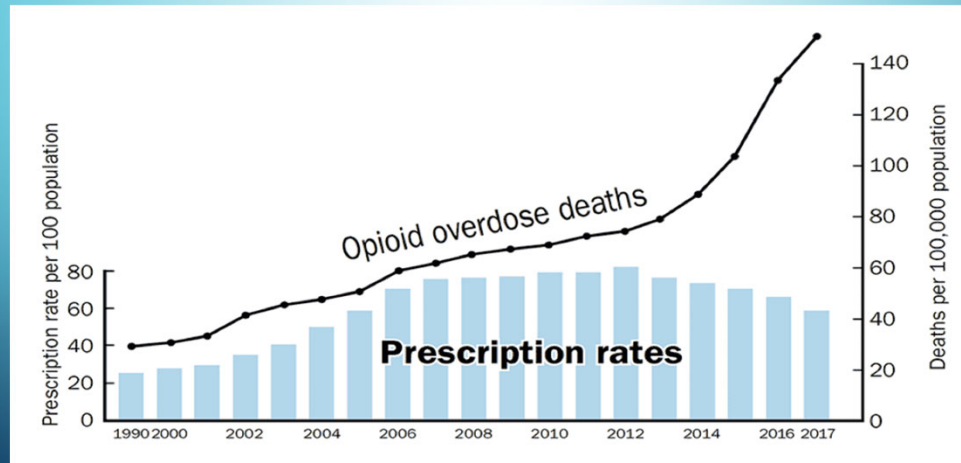
ACUTE PAIN VS CHRONIC PAIN

<ul style="list-style-type: none"> • Lasts less than 6 months - temporary • Warning to your body • Caused by something specific <ul style="list-style-type: none"> • Broken bone • Burns • Cuts • Labor/childbirth 	<ul style="list-style-type: none"> • Ongoing – longer than 6 months • Caused by an underlying issue <ul style="list-style-type: none"> • Musculoskeletal • Neuropathic • Cancer pain • Abdominal pain • Pelvic pain • Podiatric (foot and ankle) pain • Post-op pain • Miscellaneous
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THE OPIOID EPIDEMIC: PRESCRIPTIONS VS. DEATH



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PAIN BY THE NUMBERS

- 20.4% (about 1 in 5 Americans) had chronic pain
- 7.4% (36% of adults who had chronic pain) had high-impact chronic pain

(Zelaya et al., 2020)

- 5-8 million patients with chronic pain are treated with opioids

(Lazaridou et al. 2020)

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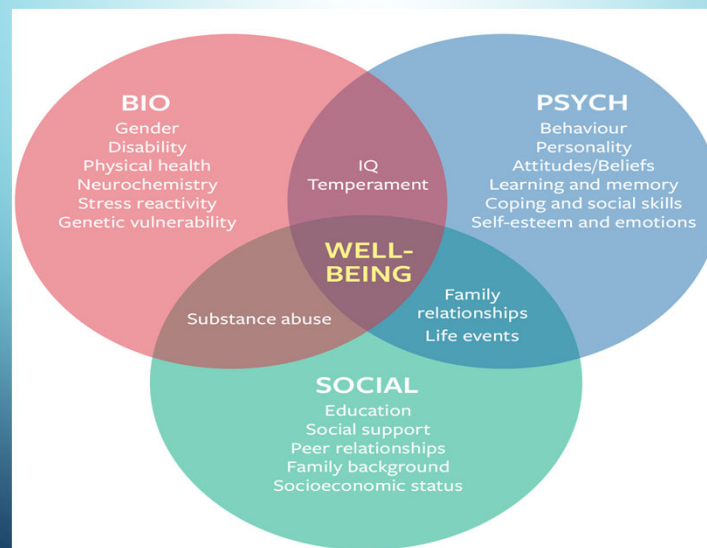
CO-OCCURRING PAIN AND ADDICTION

- Rates of chronic pain are high in patients in OUD treatment programs
 - Methadone maintenance:
 - >60% any chronic pain
 - 37% severe chronic pain
 - Buprenorphine-naloxone:
 - 36% with chronic pain
- In patients with chronic pain, rates of OUD vary
 - In large health care system, 26% of patients on long-term opioid therapy with OUD
 - In clinic sample, 24% of commercially insured and 20% in Medicaid sample with OUD
 - Rates of addiction 8-12%

(Barry et al., 2009; Rosenblum, et al., 2003; Jamison et al., 2000; Barry, et al., 2013; Boscarino et al., 2010; Edlund et al., 2010; Vowles, 2015.)

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BIOPSYCHOSOCIAL MODEL



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UNIVERSAL OPIOID PRECAUTIONS

Table. Summary of Universal Precautions in Chronic Opioid Therapy for Cancer Pain^{5,14}

Step	Precaution	Explanation
1	Pain diagnosis and differential	Make an appropriate diagnosis of pain and/or differentials, and determine the need for chronic opioid therapy.
2	Initial screening	Prior to starting opioid therapy, screen all patients using clinical interviews, physical examination, and risk-assessment questionnaires to identify those at risk for nonmedical opioid use; a comprehensive psychological assessment screening is particularly important.
3	Informed consent	Discuss with patient the risks, benefits, adverse effects, and alternatives of opioid therapy; provide opioid education on safe use, storage, and disposal.
4	Treatment agreement	Obtain a verbal or written treatment agreement (opioid management plan) outlining patient obligations, clinician responsibilities, and treatment expectations.
5	Opioid therapy +/- adjuvant analgesics	Individualize opioid selection and dosing based on prevailing conditions (e.g., patient's health status, previous opioid exposure, present contraindications, and anticipated complications); supplement therapy with nonopioid and/or adjuvant analgesics when applicable.
6	Subsequent monitoring	At subsequent follow-up visits, conduct periodic UDTs, use the PDMP if available, and observe behavioral patterns to help determine treatment adherence and support therapeutic decision-making.
7	Pain management outcome assessment	Conduct pre- and periodic post-intervention assessments of pain intensity and functional level to measure treatment progress and justify the rationale for continual opioid therapy. Use the "five A's" of pain management outcome assessment: analgesia, activity (function), adverse effects, aberrant behavior, and affect (mood).
8	Comorbid conditions	Periodically review and address the pain diagnosis and other comorbid medical and psychological conditions, including substance use disorders, as these may evolve.
9	Specialist referral	Consider referral of patients at high risk for abuse and those with complex opioid regimen to palliative and pain medicine specialists for co-management.
10	Documentation	Carefully document all clinical encounters to ensure optimal patient care and minimize any medicolegal ramifications or regulatory scrutiny.

Abbreviations: UDT, urine drug tests; PDMP, prescription drug monitoring program.sss

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NONINTERVENTIONAL TREATMENTS

- NSAIDs (ibuprofen, naproxen, meloxicam, indomethacin, Toradol, Celebrex)
 - Work by blocking inflammation and altering pain perception in the CNS
 - First-line tx for acute and chronic conditions for pain and inflammation
 - Low abuse potential
 - Potential side effects:
 - Gastrointestinal
 - Renal
 - Cardiovascular
- Acetaminophen (Tylenol)
 - Works by inhibiting prostaglandin synthesis in the CNS that are responsible for pain transmission and fever
 - Useful when NSAIDs are contraindicated
 - Liver damage can occur with large doses
 - Never exceed more than 4,000 mg in 24 hours



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NONINTERVENTIONAL TREATMENTS

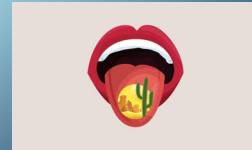
- Topical Pain Medications (local anesthetics, topical NSAIDs, capsaicin)
 - Provide localized relief, targeting tissue on which they are directly applied
 - Lidocaine (patch and gel) – numbs
 - Diclofenac NSAID (available in patch and gel)
 - Capsaicin (patch and cream) – “burns out” small peptides in cutaneous nerves that are involved in sending pain transmissions to the brain
 - When to use:
 - Patients have adverse effects with oral medications
 - There is poor compliance with oral medication
 - Patients do not want to take pills
 - Can be used as stand-alone or with oral medication
 - Side effects
 - Mild skin irritation
 - Capsaicin – burning sensation



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NONINTERVENTIONAL TREATMENTS

- Muscle Relaxants (Baclofen, tizanidine, Flexeril, methocarbamol)
 - Reduce spasticity and alleviate pain caused by muscle spasm
 - Usually limited to treatment of spasticity from a CNS lesion or acute painful muscle spasms
 - Long-term use of muscle relaxants in chronic pain is controversial
 - Potential side effects:
 - Dizziness
 - Drowsiness
 - Dry mouth
 - Weakness



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NONINTERVENTIONAL TREATMENTS

• Antidepressant Medications Used for Neuropathic Pain

- Use resulted from clinical observations
 - TCAs – work by blocking reuptake of norepinephrine and serotonin
 - Amitriptyline (Elavil)
 - Nortriptyline (Pamelor)
 - SNRIs – work by blocking reuptake of serotonin and norepinephrine
 - Duloxetine (Cymbalta)
 - Venlafaxine (Effexor)
 - Milnacipran (Savella) - FDA approved only for fibromyalgia
 - SSRIs are **NOT RECOMMENDED** for treating neuropathic pain
- When to use:
 - Neuropathic pain (diabetic peripheral neuropathy, nerve entrapment: CTS, postherpetic neuralgia, trigeminal neuralgia, intercostal neuralgia, stump neuromas)
 - Fibromyalgia – characterized by widespread pain and pain caused by nonpainful stimulus (tactile allodynia)
- Contraindications
 - Use with caution in combination with other medications that also inhibit the reuptake of serotonin (cyclobenzaprine, Tramadol, SSRIs, triptans (used for migraine) due to risk for serotonin syndrome
 - Discontinuation of these medications should be phased out gradually over a 1- to 2-week period rather than abruptly



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NONINTERVENTIONAL TREATMENTS

• Antiseizure Medications Used for Neuropathic Pain

- Commonly used medications
 - Gabapentin (Neurontin) – works by blocking alpha2/sigma-calcium channel
 - Pregabalin (Lyrica) – works by blocking alpha2/sigma-calcium channel
 - Carbamazepine (Tegretol) – stabilizes neurons by blocking sodium channels
- When to use:
 - Neuropathic pain
 - Fibromyalgia
- Potential side effects:
 - Gabapentin and Lyrica may worsen vertigo and result in mild to moderate dizziness, sleepiness, and edema.
 - Carbamazepine
 - Not an option for patients with hx of bone marrow depression.
 - CBC necessary before therapy
 - May inhibit metabolism of TCAs and vice versa (using them together may elevate levels of both drugs)



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NONINTERVENTIONAL TREATMENTS

- Opioids (codeine, hydrocodone, oxycodone, morphine, hydromorphone, fentanyl, methadone)
 - Work by activating receptors that modulate our perception of painful stimuli (nociceptive pain)
 - 3 opioid receptors: mu, kappa, delta
 - Primary analgesic effect is via the mu receptor
 - When to use
 - Can be first-line for acute pain
 - Second-line drugs for chronic pain
 - Potential side effects
 - Constipation
 - Nausea
 - Itching
 - Sedation
 - Respiratory depression
 - Low testosterone
 - QT interval prolongation – specifically with methadone

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OPIOIDS

- Short-acting oral opioids
 - Less severe pain or patients unable to tolerate stronger opioids
 - Codeine
 - Moderate to severe pain
 - Hydrocodone/acetaminophen
 - Oxycodone or oxycodone/acetaminophen
 - Severe pain
 - Morphine
 - Hydromorphone (Dilaudid)
- Long-acting opioids
 - Oxycodone
 - Morphine
 - Dilaudid
 - Fentanyl (transdermal patch)
 - Methadone
- Other narcotic and narcotic-like pain medications
 - Nucynta (tapentadol)
 - Tramadol



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OPIOID CONVERSION

Morphine Milligram Equivalents (MME)	
Opioid	Conversion Factor
Codeine	0.15
<i>Fentanyl Transdermal (mcg/hr)</i>	2.4
Hydrocodone	1
Hydromorphone	4
Methadone	
1-20 mg/day	4
21-40 mg/day	8
41-60 mg/day	10
61-80 mg/day	12
Morphine	1
Oxycodone	1.5
Oxymorphone	3

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INTERVENTIONAL TREATMENT OPTIONS

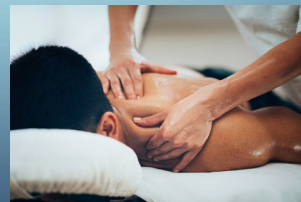
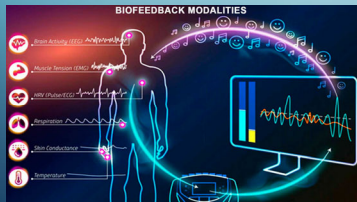
- Epidural steroid injections – conservative traditional alternative to surgery
 - Lumbar and cervical radiculopathy – most common use
 - Spinal canal stenosis
- Facet joint procedures (facet joint injections, medial branch blocks, radiofrequency ablations)
- Sacroiliac joint injections
- Trigger point injections for myofascial pain
- Joint and bursa injections (shoulders, elbows, hips, knees)
- Injections for headache (occipital nerve blocks and botulinum toxin)
- Nerve blocks
- Spinal cord stimulation
- Intrathecal pump
- Surgery



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MULTIMODAL APPROACH TO PAIN

- Physical therapy
- Complementary treatments
 - Acupuncture
 - Cognitive behavioral therapy
 - Biofeedback
 - Therapeutic massage
 - Hypnosis
 - Chiropractic treatment/osteopathic manipulation



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AVOIDING OPIOID ABUSE

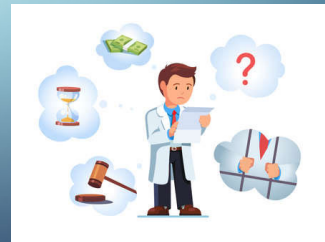
- US opioid overdose epidemic
 - >40 people die every day from overdoses involving opioids
 - >165,000 deaths from overdose related to prescription opioids
 - 4.3 million Americans engaged in non-medical use of prescription opioids in the last month
- CDC Guideline for prescribing opioids for chronic pain
 - Non-opioid therapy is preferred for chronic pain
 - When opioids are used, the lowest possible effective dosage should be prescribed
 - Exercise caution and monitor patients closely
 - Caution increasing to ≥ 50 mme/day, and avoid increasing to ≥ 90 mme/day
 - Review PDMP data
 - Urine drug testing
 - Avoid concurrent opioid and benzodiazepine prescribing
 - At each visit document analgesia activity, side effects, and aberrant behavior
 - Offer treatment for opioid use disorder
- Opioid Agreement



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RISK FACTORS FOR ADDICTION IN PAIN PATIENTS RECEIVING CHRONIC OPIOID THERAPY (COT)

- Prior history of abuse – best predictor
- Pain-related functional limitations/impairments
 - Sleep disturbance
- Current cigarette smoking
- Family history of substance abuse
- History of mood disorder
 - PTSD
 - Depression
- Childhood history of sexual abuse or neglect
- Involvement in the legal system
- Significant psychosocial stressors



(Chang & Compton, 2013)

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OPIOID USE DISORDER

DSM-5 diagnostic criteria

- A. Problematic pattern of opioid use** leading to significant impairment and distress, as manifested by at least 2 of the following in a 12-month period:
1. Opioids taken **in larger amounts over a longer period** than was intended
 2. Persistent desire or **unsuccessful effort to cut down or control use**
 3. A great deal of **time is spent in activities necessary to obtain, use, or recover** from the opioid/effects
 4. **Craving, or strong desire** or urge to use opioids
 5. Recurrent opioid use resulting **in failure to fulfill major role obligations at work, school, or home**
 6. Continued use despite persistent **recurrent social or interpersonal problems**
 7. **Giving up important social, occupational, or recreational activities** because of use
 8. Recurrent use in situations in which it is **physically hazardous**
 9. Continued opioid use despite knowledge of having **persistent or recurrent problem**
 10. **Tolerance**
 11. **Withdrawal**

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TREATING CHRONIC PAIN IN SUD PATIENTS RECEIVING CHRONIC OPIOID THERAPY (COT)

Patients with untreated addiction: focus on addiction treatment

- Patients with ACTIVE ADDICTION are NOT CANDIDATES for COT
- Untreated addiction results in poor functionality → poor pain outcomes
- Should be referred to formal addiction treatment

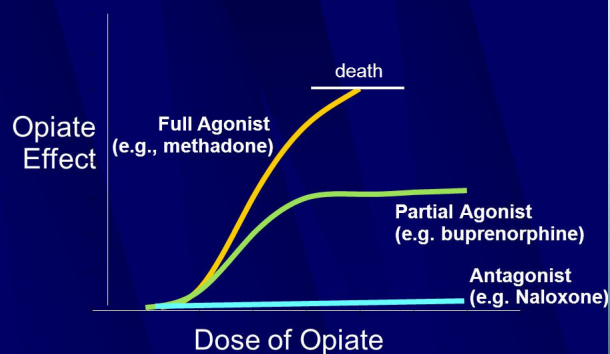
Patients with addiction in remission: focus on relapse prevention

- Goal of treatment is the same as for all chronic pain patients: improve pain and maintain functionality
- Indicators of successful pain management include: patient's ability to comply with regimens, engage in cognitive behavioral management strategies, utilize positive coping skills to manage stress, establish better social support systems
- Management of comorbid neuropsychiatric complications to maximize functionality

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MEDICATIONS FOR OPIOID USE DISORDER

Partial vs. Full Opioid Agonist



FULL AGONIST

- Methadone

PARTIAL AGONIST

- Buprenorphine

ANTAGONIST

- Naloxone
- Naltrexone

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COMMON MISCONCEPTIONS

- Maintenance opioid agonist treatment (OAT) treats pain
 - Opioid-induced tolerance
 - Lack of response to a drug
 - Need higher doses of drugs to receive the same effect
 - Cross-tolerance
 - Opioid-induced hyperalgesia
 - Paradoxical increase in sensitivity to painful stimuli
 - Driven by neuro-plastic changes to pain perception → sensitivity
- Buprenorphine/naloxone will interfere with pain control in patients undergoing surgery
- Patients physically dependent on OAT need to be maintained on daily equivalence before receiving analgesic effect from other opioids

(Alford, Compton, & Samet, 2006)

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SHORT-TERM PAIN MANAGEMENT WHEN ON OPIOID AGONIST TREATMENT (OAT)

- Consider split dosing on TID or QID schedule
 - Analgesic effect ~4-8 hours
- Dose titration is also a possibility
- Ok to give short acting opioids in addition to OAT (for pain of short duration only)
 - Patients on OAT will have higher tolerance

(Alford, Compton, & Samet, 2006)

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PERI-OPERATIVE PAIN MANAGEMENT

- Prior recommendations suggested stopping buprenorphine prior to surgery
- Assumption that buprenorphine blocked the effectiveness of additional opioids
- Limited evidence in perioperative medicine
 - Study found patients on buprenorphine received higher doses of short acting opioids to achieve adequate analgesia, but experienced similar pain control, length of stay and functional outcomes

(Mehta et al., 2020)

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WHERE DID 5-DAY RULE COME FROM?

- University of Michigan Protocol
- Stop buprenorphine/naloxone for 5 days before surgery, transition to short-acting full agonist opioids
- Ensure opioid receptor availability for pain management
- MI provider actually took back; no evidence

(Stern, 2015; Ward, Quaye, & Wilens, 2018)

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PERI-OPERATIVE PAIN MANAGEMENT

Most addiction medicine providers recommend continued use of buprenorphine when possible

- No consensus on recommendations
- Study outcomes have been conflicting
- Some protocols recommend decreasing buprenorphine dose for high-risk surgeries

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RECOMMENDATIONS FOR PAIN CONTROL

- Acknowledge patient's pain and offer reassurance
- Offer medications to treat opioid use disorder (buprenorphine/naloxone, methadone) as adjunct
- Use opioid analgesics, often at higher doses because of cross-tolerance
- Consider injections or other interventions (nerve blocks, lidocaine patch)

Tailor treatments:

- Have patient-centered conversations
 - What are patient's primary goals?
 - Recognize this is just the start of conversation
 - Use motivational interviewing and non-judgemental techniques

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OPTIMIZING NON-OPIOID ADJUNCTS

- Perioperative use of gabapentin promotes opioid cessation after surgery and decreases duration of post-operative opioid use
 - 1200 mg perioperatively and 600 mg TID post-operatively
 - Effect via voltage-gated Ca channels in CNS
- Optimize anti-inflammatory medications and muscle relaxants
 - Ibuprofen and acetaminophen
 - Cyclobenzaprine or methocarbamol
 - Scheduled

(Hah et al, 2018)

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GENERAL PRINCIPLES FOR OPIOID TX IN PATIENTS WITH OUD

- Use more potent opioids with shorter dosing intervals compared to opioid naïve patients
- Schedule continuous opioids for better long-acting pain control
- Recognize maintenance agonist does not provide adequate analgesia

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OPIOID WITHDRAWAL

Used for- patients:

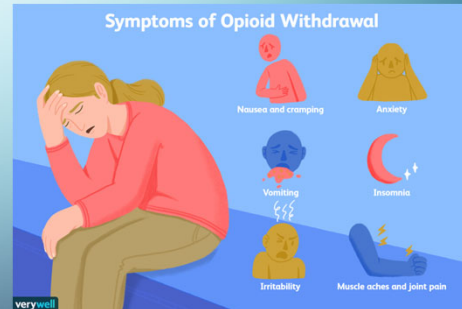
- With untreated opioid use disorder
- On MAT who are ending treatment
- Using opioids who are to be initiated on extended-release naltrexone
- Ending chronic opioid treatment for pain management

Clinical manifestations

- Gastrointestinal distress
- Flu-like symptoms
- Sympathetic nerve and central nervous system arousal
- Other

Medications

- Opioid agonists: methadone and buprenorphine
- Alpha-2 adrenergic agonists: clonidine and lofexidine
- Adjunctive medications: diphenhydramine, hydroxyzine, benzodiazepines, dicyclomine, loperamide, ondansetron, promethazine, trazodone, mirtazapine, ibuprofen, acetaminophen, cyclobenzaprine, baclofen



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CASE STUDY

Background

- **GL - 74 year old male with chronic low back pain r/t diffuse DDD**
- **High risk medication use:**
 - Overuse of prescribed Tylenol, ibuprofen, and gabapentin
 - Multiple hospitalizations for oversedation, confusion, overdose
 - Taking non-prescribed controlled meds (Soma, Klonopin, "Percocet")
- **Referred to other PM programs who declined to accept patient**

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CASE STUDY

Pain management course of care

- **1st visit (April 2019)**
 - Patient was incarcerated 20 years for distribution of methamphetamine. Denies use in 20+ years.
 - Started part time work as a janitor with frequent exacerbations of pain
 - Admitted to use of "Percocet" given by "friend"
 - **Plan:**
 - UDS +OPI - sent for quantification
 - Referral to acupuncture
 - Declined referral to PT or OMT
 - Patient educated on dangers of black market medications. He agreed to take only prescribed meds.
 - Repeat UDS in 2 weeks
- **Follow Up visit (May 2019)**
 - UDT positive for heroin and metabolites
 - Patient seemed genuinely surprised
 - Repeat UDS negative for all analytes
 - Opioid Agreement
 - Start trial oxycodone
 - Patient stabilized on morphine 15mg TID → later increased to QID

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CASE STUDY

Pain management course of care

- **Subsequent visits**
 - **Pandemic**
 - not working
 - not volunteering
 - isolating more
- **Nov/Dec 2020 Oral swab positive heroin, methamphetamine**
 - Patient agreed to more frequent in-person visits with UDS/UDT
 - SBIRT services
- **April 2021 - present**
 - Added PT services
 - Continued with therapist for additional support
 - Continues to test consistent with prescribed medication

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INTEGRATION OF PROGRAM PARTNERSHIPS AT WCCHC

- Medical Services
- Behavioral Health Services
 - Psychology
 - Psychiatry
- Drug Treatment
 - SBIRT services
 - Malama Recovery outpatient
- Physical Therapy
- Acupuncture
- Osteopathic Manipulation
- Supplemental Programs
 - Self-Management Classes
 - Fitness Center
 - Smoking Cessation
 - Case Management
- Ha Ola Village

